Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Susan Mooney CRNA 6161 Harry Hines Ste 224 Dallas, Tx 75235	MFDR Tracking #: M4-06-2242-01 DWC Claim #: Injured Emp
Respondent Name and Box #: Insurance Company of the State of PA Rep Box: 19	Date of Inju Employer N Insurance Carrie

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary; taken from the Table of Disputed services: "We received authorization. Provider received authorization."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $521.07
3. CMS 1500(s)
4. EOB's
5. Preauthorization Approval Letter dated 01/14/05

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...Carrier denied this preauthorized services because it was not medically necessary to treat the 1993 compensable injury based on an ongoing disputed concerning the extent of that injury..."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Denial Code(s)	Part V Reference	Amount Due
01/20/05	00630-QZQS	R, ZFK	1 - 6	$521.07
Total Due:				$521.07

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under procedure code 00630-QZQS for DOS 01/20/05.
2. This service was denied by the Respondent with denial reasons:

- R – "Charge unrelated to compensable injury."
- ZFK – "The charge for this procedure exceeds the fee schedule or usual and customary."

3. The Requestor was given preauthorization for Anes - Dx/Tx Nrv Blks & Inj; Prone pstn destruct – neurolyt – facet jt nrv ;L/S – EA add level and Fluoro guid &localiz needle/cath-spine inj procs, according to the preauthorization letter dated Jan 14, 2005 and certification number 05010421327676.

4. The Respondent denied reimbursement based upon the charge unrelated to compensable injury, a review of the submitted documentation and notes in the Dispute Resolution Information System Contact Data (DRCD) stated, "Review of CMS 1500 revealed Dr. billed w/ Dx 722.80 & 997.00. DWC 21 dated 4/27/94 carries states: "Disputing purchase of codetron as pre-certificated cannot certify the effectiveness of this unit b/c the TD cannot provide information to justify purchase request has been denied. The respondent filed a 2nd 21 filed dated 3/13/95 which stated: "TD gave MMI of 3/8/95 w/ 14% IR. We have initiated benefits to the Clmt for IIBs taking credit for an overpayment of 4/7th week at the end of IIBs. Benefits are to be paid until 12/27/95. The clmt's medical will continue to be paid according to the act and the Respondent issued another DWC 21 (3rd) dated 10/2/95 which stated: "Rcvd revised Twcc 69 from DR. Selby stating clmt has 17% impairment." (4th) Based on Des Doc report the employee was at MMI with a 13% IR and IIBs paid based on MMI date of with 14% or all IIBs paid." The respondent has not filed a filed a DWC-21 disputing extent of injury; therefore the carrier's denial of "R" is not supported.

5. The MAR for code 00630-QZQS is as follows:

   44 minutes ÷ 15 = 2.9 units
   CPT code 00630-QZ =8 units + 2.9 units = 10.9 units
   10.9=11units
   $47.37 x 11 units =$521.07 (MAR)

6. Therefore, according to rule 134.202(c) (1) reimbursement of $521.07 is recommended. .

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $521.07, plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER :

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
[redacted]	[redacted]	04/16/08

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.